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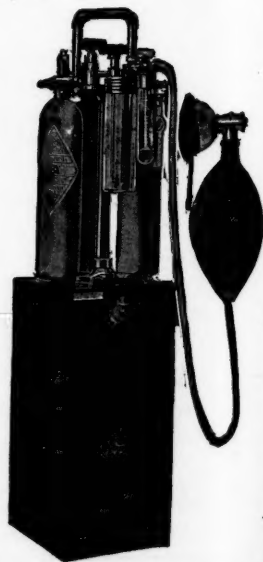
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## ORIGINAL ARTICLES

### OBSERVATIONS ON CANCER OF THE UTERUS.\*

LINCOLN DAVIS, M.D.  
BOSTON, MASS.

Doctors are undoubtedly heartily sick of papers and talks on the subject of cancer. The conscientious doctor, however, is still more heartsick when confronted by the reality itself as represented by the average case as it presents itself at his office in a state of hopeless advancement. As long as the problem remains with us, and it appears to be more pressing each year, we must study it, talk about it, and fight it relentlessly, in the profession and out, until some day, let us hope, it will be solved.

Surgeons, roentgenologists and radiologists are all contending against this enemy of the human race with increasing intensity. All are clamoring for the early recognition and treatment of the disease, and with this end in view a nation-wide and almost world-wide campaign is being carried on among the people and in the profession. The laity is being made acquainted with the early signs and symptoms of the disease, and the medical profession, which is far from blameless in overlooking the early stages of this insidious malady, is also receiving its due quota of admonishment as to the costly results of hasty and superficial physical examination, or worse still, lack of examination.

The surgical clinics of this country are crowded with cancer cases, and the more experienced hospital surgeons are devoting many hours a day to difficult, tedious and critical operations in the attempt to thoroughly eradicate deep-seated new growths with their tributary lymphatic drainage areas. Almost as many exploratory laparotomies are being done and the abdomen closed without even an attempt at removal of the growth, on account of its widespread dissemination. I do not mean to criticize the procedure of exploratory laparotomy, quite the reverse, I believe in it thor-

oughly, but it should be resorted to at an early stage on the suspicion of malignancy, when there is hope of cure. I only deplore the frequency with which inoperable carcinoma is found.

At the Massachusetts General Hospital in the year 1919, there were 348 operations performed for carcinoma of various organs. In the year 1920, 432 cases of malignant tumors entered the wards for treatment. How many of these cases have been benefited by their operations? How many will be cured? We do not know.

At times the surgeon is assailed by a feeling of overwhelming discouragement, when after an apparently most radical and thorough eradication of some deep-seated cancer, with immediate recovery of the patient, and gratifying cessation of previous distressing symptoms, at the end of six months unmistakable signs of recurrence appear. When this is repeated several times, we sometimes ask ourselves, what is the use? On the other hand, to those who have had the care of cases of unoperated cancer to the bitter end, and very few surgeons have this soul-trying experience; to those who have stood by and watched the slow wasting, the pain, the hemorrhages and the foul discharges, using merely palliatives and morphine to tide the case along, to such I am sure, almost any other way seems preferable.

There is, however, a brighter side to the picture. Radical surgical removal of deep-seated cancer yields a definite percentage of really permanent cures, varying with the locality affected, but sufficient to spur the surgeon on to further efforts. In organs where the development of new growths is subject to detection by sight and palpation, as in the female breast, where consequently it is possible to get cases at an early stage, surgical operation gives most excellent results. Recent figures reported before the meeting of the American Surgical Association last May showed approximately 60 per cent of five-year cures where the cancer was confined to the breast at the time of operation. Cancer of the lip gives perhaps even better figures.

Cancer of the uterus, too, should be detectable at an early stage in a large number of cases. The cervix is accessible to palpation and inspection by

\*Read before the quarterly meeting of the Rhode Island Medical Society held at Woonsocket, Sept. 7th, 1922.

the simplest of methods. The symptoms are often fairly distinctive and yet the early detection of cancer of the cervix remains a rarity.

According to the mortality records of the United States, about 12,000 women died of cancer of the female generative organs in 1914. Of these cases, cancer of the uterus makes up at least 90 per cent. Inasmuch as there is an estimated annual increase in the death rate from cancer of about  $2\frac{1}{2}$  per cent, it is fair to assume that at the present time at least one thousand women die every month in the United States as a result of cancer of the uterus.

For every case that ends fatally, at least one new case is developing, hence one thousand new cases of cancer of the uterus are developing in the United States every month. It is these new cases which concern us. How are we going to detect them, and how treat them?

I regret that I cannot accurately describe to you the precancerous cervix. There are certain conditions of the cervix which are generally considered to predispose to the development of cancer and this is undoubtedly so. Cases with deep indurated lacerations of the cervix, with eversion, and ectropion, which bleed on touch, are generally regarded with suspicion, and a plastic operation or amputation advised, especially if the patient is nearing the menopause. Such advice is sound. The practice of repairing lacerations may of course be carried to absurd lengths, for every woman who has borne a child has a lacerated cervix, which may be the potential site of cancerous degeneration. Common sense and good judgment are required here as in everything else. A cervix which is suspicious might at least be kept under observation and be inspected three times a year. While the precancerous cervix still remains *terra incognita*, there are certain definite clinical manifestations in some forms of early squamous cell carcinoma of the cervix. A granular area with definite margin which is distinctly elevated above the surrounding tissue, which is hard to the touch, and bleeds easily, especially if it is confined to one lip, is very suspicious. On the other hand the inverting type of adenocarcinoma of the cervix may honeycomb the entire structure with little or no external manifestation.

Two cases have recently come to my attention, in which the surgeon who first saw them in the Outpatient Department, made a tentative diagnosis

of cancer of the cervix. They were admitted to the wards under the charge of other surgeons. Both were curetted, and specimens of tissue excised from the cervix for microscopic examination, in one case a trachelorrhaphy being done. In both cases the pathological report was negative. The patients were discharged without further treatment. In one case at the end of a year there was unmistakable cancer of the posterior lip of the cervix, which was, strange to say, still well localized. A complete hysterectomy was done. Microscopic examination of the uterus showed typical early squamous cell carcinoma of the cervix. The patient made a good recovery and is well up to date. In the other case the outcome was less fortunate, the patient re-entering the hospital within six months, with hopelessly advanced carcinoma involving the parametrium and wall of the pelvis.

How are such occurrences to be explained? The microscopic sections obtained at the primary entries were reviewed in both cases, and showed no carcinoma. We can only say that the site of the disease was missed in the removal of the specimens. This may easily occur when the disease begins in a small isolated island of tissue. The closest co-operation between surgeon and pathologist is desirable, the latter should see the specimen cut and be familiar with its relations in situ. In the case of curettings all the tissue should be saved and examined.

I firmly believe that the clinical presumption of early malignancy is often sufficient to warrant a complete hysterectomy whether abdominal or vaginal, irrespective of the microscopic findings. A woman who has passed the menopause by a year or two and then suddenly begins to flow, should surely have the uterus removed even if curettings are reported normal.

When two such failures in early diagnosis as have just been recorded occur in a large, well equipped metropolitan hospital, it disarms such criticism of the solitary general practitioner who often is forced to make his examinations under protest, in a poor light, and occasionally lets a case slip by. Such slips should spur us all on to greater watchfulness and care.

Sometimes we are confronted by some such attitude as this on the part of a physician who may say, "What is the use of making an early diagnosis anyway, surgery has never accomplished a cure,

that I know of, and the longer the patient may remain in ignorance of her real condition, the better for her."

In order to get physicians to cordially co-operate with surgeons in the early detection and treatment of cancer of the cervix it is up to the surgeon to show that the results of operations are really worth while.

Twenty years ago there was much complaint on the part of surgeons in regard to late diagnosis of acute appendicitis, it being rightly held that the bad results of operations were really due to delay. This has been amply proved and accepted by the profession, so that today there is little cause for complaint on this score, and often the surgeon is urged to operate by his more radical medical colleague while he is still assailed by doubts as to the diagnosis.

Now what results may reasonably be expected in the surgical treatment of cancer of the uterus? There is little difference of opinion in regard to the treatment of adeno-carcinoma of the body of the uterus. This disease remains localized in the uterus for a comparatively long time. When it does metastasize, it usually does so by breaking through the peritoneal coat of the fundus and invading the general peritoneal cavity, giving unmistakable evidence of its presence. The results of total hysterectomy are excellent. The operation is comparatively simple and safe, the parametrium does not require removal, and the ureters may be left undisturbed, nor is it necessary to remove a cuff of vaginal wall. The primary mortality is low and the percentage of five-year "cures" in the neighborhood of 75%.

When it comes to cancer of the cervix the situation is quite different. Unfortunately this condition is much commoner than cancer of the body, being found six to eight times oftener than the latter. There is at the present time a great divergence of opinion as to the best treatment. There is a distinct trend of opinion just now in favor of radium treatment as opposed to operative treatment. Personally, I cannot as yet share this view. I will admit that I am not competent to express an opinion as to the value of radium in the cure of cancer of the cervix. I have personally not happened to see a single definitive cure by radium as yet. I would not, however, deny that such exist.

Hitherto the cases referred for radium treatment have been generally the most advanced and hopeless cases in which it is perhaps not fair to expect a cure. There have been some very remarkable palliative effects, which are indeed a hopeful sign for the future. It is only within the last two or three years that radium has been used in a scientific and intensive manner for this disease, and it is still too soon to judge of end results. By its encouraging results in advanced cases radium has undoubtedly earned for itself the right to a fair trial alongside of surgery in the more favorable cases. It is obviously unfair to refer for treatment by radium only hopelessly advanced cases while retaining all early cases for surgical treatment. The employment of radium, however, in all locally favorable cases in which there are contra-indications to surgical operation on the part of the general system of the patient, should provide in due time ample means for a fair comparison of results obtained by both procedures. I must confess that I am unwilling as yet to abandon the operative treatment of this disease in appropriate cases until more evidence of lasting cures by radium are at hand. The radical operation has proved itself of real curative value in the past and is, I believe, capable of a still better record in the future.

My experience with the operation at the Massachusetts General Hospital comprises 35 cases operated on during the last ten years. Total abdominal hysterectomy, including a liberal cuff of vaginal wall and wide removal of parametrial tissue is the operation of choice. This has been done in 34 cases. Systematic dissection of the pelvic lymph nodes has not been attempted. Ligation of the internal iliac arteries has not proved in my hands to be of material advantage, and has been given up since the early cases. In cases presenting a bulky cauliflower out-growth from the cervix, filling the vault of the vagina, preliminary curettage and cauterization followed ten days later by radical hysterectomy has been done. Otherwise the operation is done in a single stage without cauterization or curettage of the growth.

Simple curettage and cauterization, or cauterization combined with ligation of internal iliac, and ovarian vessels, has been done in a number of cases in earlier years as a palliative measure, but

lately has been entirely abandoned in favor of radium in those cases in which radical operation is contra-indicated.

Vaginal hysterectomy has been done in a single case in which the disease was discovered at an early stage and seemed to be entirely confined to the cervix. This procedure is not advocated except under unusual circumstances.

In the total of 35 cases of hysterectomy for cancer of the cervix, 34 radical abdominal operations and one vaginal hysterectomy, there have been three operative deaths, an operative mortality of 8.5%. There has been no mortality in the 15 cases operated on since 1917. The operability rate has been approximately 35%. That is, about one in three cases seen, has been proved suitable for this operation.

Last May I looked up the results of all my cases in which a radical operation had been done, in which a period of five years had elapsed since operation. I will quote from the report: "Total number of cases, 20. Nineteen radical abdominal hysterectomies and one vaginal hysterectomy. All 20 cases have been traced..

"In 3 cases, death occurred as an immediate result of the operation, giving an operative mortality of 15 per cent." This percentage has been reduced by subsequent cases to 8½%.

"In 7 cases the patients are now living and well more than five years after operation.

"In 1 of these cases more than 10 years have elapsed since the operation.

"In 1 case the patient died of cerebral hemorrhage without sign of recurrence seven years after operation.

"This gives a total of 8 five-year 'cures,' or 40 per cent.

"Recurrence of disease has been noted in a total of 9 cases; it took place within one year of operation in 7 cases.

"In 1 case recurrence was first noted 2¾ years after operation.

"In 1 case reported well by letter four years and four months after operation, local recurrence was noted at the end of the fifth year. The patient died five years and ten months after operation.

"All recurrences in these cases were local in the pelvis, except in one where the stomach and liver were stated by the attending physician to be the site of recurrence.

"One case classed as a 'cure' in which death from cerebral hemorrhage occurred seven years after operation, might be objected to on the ground that the cerebral condition was in the nature of a recurrence. The fact that the patient had been repeatedly examined during the first five years and found free from recurrence, and that her cerebral attack occurred very suddenly during apparent good health, and finally that there had been a previous hemiplegia prior to operation, amply justifies, I think, the exclusion of recurrence as a factor in this case. If the three-year period of freedom from recurrence is taken as a standard of 'cure,' the percentage would be raised only five points to 45 per cent.

"The most gratifying evidence of the efficacy of the radical abdominal operation is furnished by two cases in which microscopic examination of the specimens removed showed definite infiltration of epidermoid cancer into the tissues of the parametrium, yet the patients remain well more than five years after operation."

It is now my painful duty to state that one of the cases herein recorded as a five-year "cure" has since re-entered the hospital with symptoms of precordial distress and dyspnoea. The X-ray reveals a shadow in the mediastinal region suggestive of new growth. The abdomen and pelvis is clinically clear of disease. It is probable that this is a recurrence of the disease in the mediastinum. If such is the fact, the percentage of five-year "cures" is reduced by 5 per cent. It is a discouraging outcome of what seemed a great success. It simply goes to prove what is already well known, viz., that no period of freedom from recurrence guarantees a permanent cure. Recurrence may take place after periods of ten to fifteen years and more, yet in this case five and one-half years of absolute good health is certainly well worth while.

In summing up, then, the status of the radical operation for cancer of the cervix it can fairly be claimed that in an average surgical clinic about one-third of the cases are suitable for operation. The operative mortality should not be over 8½ per cent, and in some hands would doubtless be found to be under 5 per cent. Five-year "cures" can be obtained in about 40 per cent of cases operated on. If by education of the public and stimulation of the profession, cases could be brought to the surgeon at an earlier stage of the disease, far

better results than these in rate of operability, primary mortality, and number of definite cures could be confidently predicted.

There is ample pathological evidence that cancer is a local disease in its early stages. There is a stage in which cancer of the cervix is still confined to the uterus, just as there is when cancer of the breast is confined to the breast, and cancer of the lip to the lip. If in such cases of uterine cancer the entire organ is removed, cure is the logical result.

Let us all then exert our utmost efforts to find these cases and institute prompt treatment whether by operation or radium, at a time when there is a real chance of eradicating the disease.

#### ENCEPHALITIS LETHARGICA AS A COMPLICATION OF PREGNANCY, REPORT OF A CASE.

BY ANTHONY CORVESE, M.D.  
PROVIDENCE, R. I.

Beginning with the report of von Economo<sup>1</sup> from Vienna in the spring of 1917, there began to appear in medical literature disquieting accounts of a nervous disease of great virility and of unknown origin. It very soon became evident that it was of world-wide distribution; it was reported from every continent.

Because this disease predominately affected the brain and caused hypersomnia, von Economo gave it the name of encephalitis lethargica. It was the "sleeping sickness" which the lay public regarded with curiosity and alarm.

The views of the profession with regard to the true nature and etiology of the encephalitis lethargica were varied and entirely speculative. In England opinion was so far astray that for some time the disease was thought to be botulism.<sup>2</sup>

At the present time the etiology is still unknown but many facts of pathology have been cleared up by research which facilitate diagnosis and indicate lines of treatment.

The facts are these: encephalitis lethargica is an inflammation of the nervous system; its virus attacks not the brain alone, but is responsible also for encephalomyelitis, polyneuritis, and meningo-encephalo-myeloneuritis.<sup>3</sup> The most startling fact, however, although its implications are not yet un-

derstood, nor entirely verified, is that there is reason to believe that the virus of influenza is responsible for encephalitis lethargica and allied inflammations of the nervous system. The relation between influenza and certain pathological features of encephalitis lethargica were quickly noted and as Jelliffe<sup>4</sup> states it: "Practically all the neurological syndromes of influenza have been observed or described as types of complications of lethargic encephalitis."

An examination of American and English literature extending over the period of the epidemic of encephalitis lethargica reveals that although men were attacked more frequently than women, yet the mortality is always higher among women, and and the mortality among pregnant women appears to be unusually high.<sup>5</sup>

At the close of the year 1920 only eight cases of encephalitis lethargica as a complication of pregnancy had been reported in the literature of America and England and the literature of all languages up to the present day contains reports of less than twenty cases. Banister,<sup>6</sup> writing in the spring of 1921 to report a case, states that he had seen no references at all to encephalitis lethargica occurring in pregnancy.

In order of date, the following reports give interesting data:

Harris,<sup>7</sup> writing in the London *Lancet* in April, 1918, says:

"A young woman who was pregnant almost at term, ate heartily of tinned salmon March 28. The following morning she developed diplopia, bilateral ptosis, marked drowsiness and pyrexia up to 103° F. She was delivered April 2, without influence on the course of the disease, which had continued with double third nerve paralysis, drowsiness and pyrexia of 100° F., retention of urine and increasingly active delirium. Examination of the suspected food had shown a large gas-producing anaerobic gram-positive, probably spore-bearing bacillus which has not yet been identified." Harris does not state the outcome of the case nor the fate of the child.

Duncan's<sup>2</sup> case is reported with meager detail: "A married woman, several months pregnant, who had been ill a few days, was when first seen, sitting by the fireside with both eyes closed. She was dull, but spoke when addressed and could raise

the eyelids." The outcome of this case, as regards the subsequent history of the mother and child, is not given by Duncan.

Bassoe<sup>8</sup> reports his case as follows:

"A woman of 34, the mother of eight children, in the sixth month of pregnancy was attacked by epidemic encephalitis. Five weeks after the onset pulmonary edema developed and the patient died. She was not delivered. Necropsy revealed extensive petechial hemorrhages in the visceral pleura, the epicardium, the renal pelvis, the bladder and the stomach in *both* the mother and the fetus."

Sachs<sup>9</sup> in a series of seven cases had three fatalities, two of which occurred in pregnant women. In his report, the duration of pregnancy is not stated for either case. Both cases are dismissed with briefest reference. It is stated that both presented ocular symptoms, the lethargy and the ataxic and cerebellar symptoms and both were very toxic. In both cases, the duration of illness was two weeks. The question of inducing abortion was raised but dismissed. No further details are given by Sachs.

Putnam's<sup>10</sup> case had had two previous normal pregnancies and her present pregnancy was normal also. She was delivered three weeks after the onset of her illness. She did not rouse during a four-hour labor. The child was still-born; its heart had not been heard the whole day previous. Four days after the delivery, the patient died.

Neal's<sup>11</sup> case is described as follows: A woman of 25, who was five months pregnant, had an attack of influenza two weeks before the onset of encephalitis, which began gradually with headache, chills and fever, vomiting, sweating and delirium. The spinal fluid showed great increase in cells and protein, Wassermann test was negative, as was also guinea-pig inoculation for tuberculosis. Her condition remained the same for two weeks or more. She gradually recovered, the facial paralysis cleared up and she had a normal delivery at term.

The case reported by Schulze<sup>5</sup> is that of a woman of 35; the pregnancy was one month past term. On April 30, she was delivered of a child weighing ten pounds. The onset of encephalitis had occurred about a month before the patient was seen. Twenty-six days after delivery, the patient suddenly developed symptoms of pulmonary embolism and died twenty minutes later. The fate of the child is not mentioned.

Garnett<sup>12</sup> reports the following case:

The patient, a secundipara, 26 years old, had a fairly typical attack of lethargic encephalitis when she was eight months pregnant. The pregnancy was normal in every way. The patient went through a normal delivery in two hours and had no undue bleeding afterwards. The child was a normal infant weighing 6½ pounds. The puerperium was perfectly normal, with no fever and no pain. Although the milk was scanty, the mother tried to nurse the child.

She had no inclination to void and there was apparently a partial paralysis of the bladder. The only sequelae were an occasional hallucination and some pain in the legs. The particularly interesting part of this case, is the apparently painless labor and the partial paralysis of the bladder, indicating that there may have been some destruction of the posterior nerve roots simulating *tabes dorsalis*.

Brown<sup>13</sup> emphasizes the difficulties of diagnosis where encephalitis complicates pregnancy near term. The case reported by him was not correctly diagnosed until the day before the patient's death, although the onset occurred a month earlier, at two months' pregnancy. The patient was delivered by the classical Caesarian section at the urgent request of the family (for no other reason). Apparently the syndrome did not resolve itself into a picture of encephalitis until the diagnosis was made; or it did not present itself to the minds of the consulting physicians, as a possibility as in this case, several diseases were mistakenly suspected until the correct diagnosis was given and with it the prognosis which was immediately recognized as inevitable death.

Banister's<sup>6</sup> patient was a primagravida, 31, in the 36th week of pregnancy when the onset of encephalitis occurred. This case showed distinct Parkinsonism. There was a definite list to the right side; in certain respects it was symptomatic of paralysis agitans—the tremor, mask-like expression, increasing reflexes and monotony of speech. The pregnancy was terminated by induction on the 16th day of disease. The child was perfectly healthy. The pains were insidious and very effective. The child was delivered nearly four hours after induction. The patient's mental state improved after the delivery of the child, but it was a short-lived improvement, as she died three weeks

from the onset of the disease. *The whole course was apyrexial except for a slight and temporary rise to 100°.* Induction of labor was decided upon in view of the following data. The patient's condition was becoming worse; the baby was alive and it was hoped that the removal of the fetus might influence the patient's metabolism for the better. The very definite improvement for the first 36 hours after delivery gave rise to great hopes of recovery, but the experience of this, according to Banister's opinion, leaves the question of interfering with pregnancy *subjudice*.

In Haultain and Thornton's<sup>14</sup> case, pregnancy seemed to be unaffected by the disease, but the lethargy was exaggerated for the first few days after labor and especially for the first 24 hours. The patient slept through the first stage of labor without giving any sign that labor was in progress and the end of the second stage was delayed on account of defective expulsive efforts. The third stage was normal in every respect and no excess of blood was lost. The puerperium, except for the conditions noted, was uneventful; the uterus underwent normal involution. The child was quite healthy and showed no signs of drowsiness or oligopnea at birth or after.

Pollastroni<sup>15</sup> reports three cases from the Bologna maternity, two of which died. One was delivered by classical Caesarian Section, one spontaneously, and in the third labor was induced. In all three the babies were premature and died from one to eleven hours after birth. The case in which labor was induced improved after uterus was emptied, but this was of short duration, as the patient went into coma the following day and died. This corroborates Banister's opinion about the question of interfering. Pollastroni classified his cases as three types: 1st "electrical chorea type," 2nd "typical lethargic type," and 3rd "grand chorea type."

From the reports it may be said that pregnancy renders graver the prognosis of encephalitis, and that the influence of the malady upon the fetus and gestation is not different from other acute febrile diseases. Interference should not be done except as a last resort to save a viable child.

I have briefly summarized the data from American and English literature in order to arrive at some conception of the influence of pregnancy on encephalitis and vice versa. The reports reveal that mortality is high for both mother and child.

My own case presents some interesting features and I record it in full detail:

The patient, Mrs. J. E., a primigravida of 24, in the 29th week of pregnancy, was first seen on March 24th, 1921, for antenatal examination.

*History:* Family history: Mother died six years ago from "psychosis." Father living, well. Three sisters living, well. Patient has had no serious illness except usual child diseases. Catamenia began at thirteen and was always regular and normal. *Present History:* Married eight months, and pregnant for first time, last catamenia September 10th, 1921; labor due June 17th, 1922. She had moderate vomiting during early months of pregnancy and slight headache for past few days; bowels regular; no other complaint.

*Examination:* Patient is well developed and well nourished, pupils equal and reacted to light and distance, heart and lungs negative; abdomen, uterus 8 cm. above umbilicus, vertex presentation, fetal heart left lower quadrant. Pelvic measurements, interspinous 25, intercrystal 28.5, external conjugate 20.5, true conjugate 11.5. Extremities, K. J. pr=, no edema. Blood pressure 130/85. Urine Sp. G. 1021; negative for albumen and sugar. She was placed on a low protein diet and advised to report within a week.

On March 28th I was called to patient's home. She was in bed, complaining of rather severe headache, heaviness about the eyes, pain in ears and dizziness when she raised herself in bed. These symptoms had started three days ago and were rapidly increasing in severity. Examination revealed the following positive signs: Temperature 100, pulse 90, blood pressure 124/90. Face slightly flushed, slight congestion of eyelids, ear drums negative, considerable hyperaesthesia of ear lobes, especially right one, slight redness and congestion of pharynx and tonsils. Heart and lungs negative; constipation was marked throughout course of the disease. Urine somewhat concentrated but negative for sugar and albumen. In spite of normal blood pressure and urine examination, a tentative diagnosis of toxemia of pregnancy was made. She was advised to stay in bed, and was ordered colonic irrigations and milk diet.

For the next four days the temperature ranged between 99.2 and 101.8, pulse between 96 and 120. During this time she complained of dizziness, severe pain in ears, sleeplessness, and was very ner-

vous. On March 30th she stated that during the night she had an "electric shock" from her feet to her head. Urine negative, B. P. 126/84, W. B. C. 11,500. Blood urea normal. The pain in ears was so severe that I called an otologist for consultation and he reported the ear drums normal; fundi also normal.

April 2, 1922. Photophobia quite marked, very restless, some mental confusion. On account of repeated negative urine, examination and normal blood pressure, I was convinced that this was not a case of pure toxemia of pregnancy. I thought of some mental disturbance (because of mother's history) or some inflammatory condition of the brain.

April 4th. Diplopia developed. April 5th, temperature for past five days between 99.6 and 98.6. Pulse 84-96. The condition of nervousness now changed to lethargy. For next three days patient slept most of the time.

April 9th. During night she noticed defect in her speech (stuttering). I now made a probable diagnosis of encephalitis. Blood Wassermann negative.

April 10th, consultation with Dr. Chas. A. McDonald. The following is Dr. McDonald's examination:

*Cranial Nerves:* Olfactory and Nose: No disturbance in smell, and nasal passages normal. Second, Third, Fourth, Sixth and Eye: The upper part of the right disc is cloudy, otherwise disc fields and vision are normal. Pupils are equal and react to light and distance. Right sixth appears weak, left eye cannot close. No ptosis. Fifth and Mouth: Motor and sensory normal. Teeth and gums in good condition. Seventh: Facial paralysis of the left side of the peripheral type. Ninth, Tenth and Eleventh: Normal. Twelfth and Tongue: Tongue deviates to the right, and moderately coated.

*Motor System:* No paralysis, no atrophies, and no involuntary movements. Deep and superficial reflexes are normal and no abnormal ones. Slight speech impediment, otherwise skilled acts are normal. There is no co-ordination. Patient was in bed.

*Sensory System:* There is complaint of parasesthesia of the left hand and no other disturbance in the sensory system. *Mental:* Except for lethargy, no abnormal signs. *Laboratory:* Blood Wasser-

mann was negative. Spinal fluid was also negative. There was no increase in cells.

*Diagnosis:* Encephalitis lethargica. April 18, feeling better, speech defect and facial paralysis less marked. Although temperature had been normal for over a week, the patient was kept in bed for fear of respiratory paralysis. April 26th, the patient went into labor about 4 p. m. and after easy labor was delivered at 7 p. m. of a 5½-pound female child. The baby was apparently normal in every way. The patient had an uneventful puerperium, rapidly improved and by the third week of puerperal state the only residue was slight speech defect. At the time of writing, the patient is perfectly well, no diplopia, no speech defect, the only complaint is of an occasional slight headache. The child is doing well.

#### REFERENCES.

- <sup>1</sup> von Economo, C.: Encephalitis lethargica. Leipzig and Vienna, F. Deuticke, 1918.
- <sup>2</sup> Duncan, J. W.: Two cases of ptosis (?) botulism. Brit. M. J. 1:551, May 18, 1918.
- <sup>3</sup> Barker, L. F., E. S. Cross and S. V. Irwin: On the epidemic, acute and sub-acute nonsuppurative inflammations of the nervous system prevalent in the United States in 1918-1919. Am. J. M. Sc. 159:57, Feb. 1920.
- <sup>4</sup> Jelliffe, S. E.: The nervous syndromes of influenza. (In: Influenza essays by several authors. Ed. by F. G. Crookshank) Lond. William Heinemann, 1922.
- <sup>5</sup> Schulze, M.: Encephalitis in pregnancy. J. A. M. A. 74:732 (March 13) 1920.
- <sup>6</sup> Banister, J. B., and Sophianopoulos, G.: A case of encephalitis lethargica complicating pregnancy. Lancet 1:481, March 5, 1921.
- <sup>7</sup> Harris, W.: An acute infective ophthalmoplegia or botulism. Lancet 1:568, April 20, 1918.
- <sup>8</sup> Bassoe, P.: Epidemic encephalitis (nona). J. A. M. A. 72:971, April 5, 1919.
- <sup>9</sup> Sachs, B.: Epidemic central or basilar encephalitis. N. Y. M. J. 109:894, May 24, 1919.
- <sup>10</sup> Putnam, O.: Lethargic encephalitis. J. Missouri M. A. 16:260, Aug. 1919.
- <sup>11</sup> Neal, J. B.: Lethargic encephalitis. Arch. Neurol. and Psychiat. 2:271, Sept. 1, 1919.
- <sup>12</sup> Garnett, A. Y. P.: Lethargic encephalitis as a complication of pregnancy and labor. J. A. M. A. 74:1315, May 8, 1920.
- <sup>13</sup> Brown, W. M.: Encephalitis complicating pregnancy near term. Am. J. Obst. and Gyn. 1:368, Jan. 1921.
- <sup>14</sup> Haultain, W. F. and Thornton, G. O.: Labor in a case of encephalitis lethargica. Brit. M. J. 1:382, March 12, 1921.
- <sup>15</sup> Pollastroni G.: Epidemic Encephalitis and Pregnancy. Revista Medica, 2:17, February 20, 1922.

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**R. I. Ophthalmological and Otolological Society**—2d Thursday—October, December, February, April and Annual at call of *President* Dr. H. E. Blanchard, President; Dr. Jeffrey J. Walsh, Secretary-Treasurer.

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## EDITORIALS

### THE MENTAL HYGIENE MOVEMENT.

The latest and in some respects the most important movement for the betterment of the public health is that known as mental hygiene. Inaugurated by a layman who himself had passed through the shadows of mental alienation and who therefore was possessed of that living sympathy for his fellow sufferers which comes of the sharing a common experience, mental hygiene has enlisted the interest and, what is more to the point, the support of men and women in all walks of life.

And thus has been added one more limb to the already flourishing tree of preventive medicine.

When the study of mental disorders and of nervous conditions resulted in nothing more important than the labelling of patients with this or that name, usually of greek derivation, it is not surprising that psychiatry and neurology moved in circles which although they may have been, as Aristotle thought, the most perfect of figures, yet suffered the defects of all circles in that they lacked the kind of direction which makes for progress. Since furthermore medicine always takes its inspiration and many of its categories from the

reigning philosophy, and since the philosophical *milieu* of the old psychiatry and neurology was, for the most part, static, the natural result was that the efforts of our forefathers concerned themselves with the description of those "disease entities" and the construction of those marvelous clinical classifications on the iron frame-work of which they were wont to stretch their patients. All this was in its time and place of value, and for it we should be, as indeed we are, sufficiently grateful. But it had served its purpose and so with the introduction of the conception of evolution and of the comparative method into medicine it was realized before long how inadequate to the facts were the older formulas and the existing methods of approach to mental problems. If the study of bodily development was, as it proved to be, so fertile in results, why not also the study of mental development? If a knowledge of structure and of growth was a good thing for anatomy and physiology, it should be a good thing for psychology. And so it has come about that the investigation of mind from its beginnings and from within has replaced its description from without. We have to do in mental matters with no mere Lockian *tabula rasa*, passively reflecting an external world; rather are we dealing with a living structure, a moving equilibrium, attempting to adapt itself from infancy to old age, now with success, now with failure, most commonly with a moiety of both, to an ever changing and richly complex environment. If, then, a man's mind is diseased, if his emotions are at war with his reason and both with his environment, if he is depressed, miserable and ineffective, it pleases him little to know that his thoracic and abdominal viscera are tolerably healthy. What he wants is mental health and he will seek it within, perchance failing this, without the medical profession if he thinks he may find it there. Because this is so, mental hygiene derives from it not its warrant for existence merely, but also the inspiration for its hope and the rewards of its labor. In the racy language of commerce, one may say that mental hygiene fills a long felt want.

Well then what attitude shall we citizens who happen to be physicians adopt towards it? Of course we should support it, as we have supported vaccination, the purification of food and water supplies, the crusades against tuberculosis and venereal diseases—in a word, as we have supported every legitimate and intelligent effort to al-

leviate or remove disease and suffering. But let us start with clear ideas. Mental hygiene is not a movement started and sponsored by sympathetic people within and without the medical profession, who weave visionary schemes out of the fabric of dreams: they are people who deal with pressing realities, to wit, facts and figures. The insane increasing apace, the delinquent and the maladjusted born every day, the neurotic and the maladjusted are not phantoms; they are very real and have real reasons for their existence; they cost us a lot of money now and in the not distant future they will cost us a great deal more. Philanthropy and charity aside, ordinary enlightened selfishness should promote an interest in mental hygiene. If in any way our burdens can be lightened, let us support those who are striving to do it. Again, the leaders of mental hygiene have no illusions: they have been practicing medicine too long for that. They do not pretend that they or anyone else can construct a new heaven and a new earth. What they do say is that if public interest and co-operation can be obtained, certain things which are bad need not be as bad as they are.

In our own State, for example, consider this. Let us suppose you are mentally so sick as to require institutional care. You may be sent to the State Hospital for Mental Diseases, without publicity, provided—you or somebody else can pay seven dollars per week for your care. If, however, you are poor—now mark this well—then the State penalizes your poverty. Oh, we know full well that some people deny it; but observe what happens. A warrant is sworn out at the instigation of the department of police, you are "charged with being insane" and having been taken to Court, in an ambulance if you are too sick for other means of transportation, your poverty and your mental affliction are there publicly proclaimed and you are committed to the State Hospital, to be detained until discharged by due process of law. Those of us who have for years not only witnessed but taken part in this procedure have been amazed at the callousness of the public opinion which can tolerate such treatment of sick people whose only reason for being in a Court is that they are poor. Perhaps this thing exists through public ignorance. Well, then, if the Rhode Island Society for Mental Hygiene can accomplish no more than the abolition of this anachronism it will have deserved well of every citizen in the State.

## HEALTH INSURANCE.

Good health is one of the most cherished hopes of every human being. A long life free from suffering and disability falls to the lot of very few persons but is sought after by everybody. That such good fortune should fall to the lot of every one is Utopian, yet it is well known to those who realize what can be accomplished by preventive and curative measures even in their present crude state, that the health of the human race can be greatly improved, even in the most enlightened countries.

Preventative measures are indisputably a governmental function. The money spent on proved methods of public health insures large returns, and the public in general is beginning to fully realize it.

How the sick and injured can best receive efficient and adequate treatment is an open and live question. Without giving consideration to suffering entailed, it is economically a wise principle that every sick and injured person should be furnished with the very best treatment possible.

In this country the private physician and hospitals have met the problem in a fairly satisfactory manner, yet it falls short of perfection. The well-to-do have nothing to fear, for they can employ the best medical and nursing talent, but the middle class and poor are not receiving enough medical attention of high quality. To meet this need the number of hospital beds has increased enormously during present years. They are doing a wonderful work and are appreciated by the public, as evidenced by their generous support. The country is able to support still more hospitals through private contributions, the patients themselves and the public treasury. Hospitals, however, cannot meet the whole problem, particularly the care of the ambulatory case. Out-patient departments are increasing in numbers and health centers are being established, and the treatment of the ambulatory case is being solved to some extent in this manner.

With the increase in hospitals and dispensaries, the burden falls heavily upon physicians. They have their own practice to attend to and are hard pressed to attend properly to the charitable work demanded of them. People little know the hours and energy they spend in hospital duties for which they directly receive no compensation. If hospitals had to pay for medical services, their work would have to be greatly restricted. Then, too, there is

the rural population to be served, which constitute about half the country's population, for whom hospitals and dispensaries are not easily available.

Germany, England and other countries have tried to meet the medical problem by insurance to raise funds to pay government physicians. Nowhere has it been a success. Such government physicians are often political appointees and are given so much work to do that it is superficially done. Health insurance has been much talked of in this country, but there are grave objections to it.

The sick and injured must be properly taken care of and it is up to physicians to do it well. Since it is their burden, it is high time that they went about deciding how it is to be done. During the last two years the American Medical Association has given considerable attention to the subject but no comprehensive solution has been propounded. If physicians do not map out a program, politicians will, because the public demand, offer their solution which is not likely to properly serve the public nor the physicians.

There are physicians enough in this country to take good care of all the sick and injured if the time of all physicians is utilized, and plenty of money in the country to amply pay the physicians for their services.

## THE PHYSICIAN AND THE ELECTIONS.

The biennial elections will be held in a few days throughout this part of the country. We wonder if the physician realizes the responsibility as well as the opportunity which he possesses to further any piece of effective legislation and at the same time help to quash any piece of vicious legislation. As the doctor goes on his daily rounds, he passes the time of day with many and varied sorts and conditions of people. The conversation naturally turns upon subjects of greatest interest and as the time of the election approaches, more and more attention and conversation will be directed to the men who are up for office and to the platforms of the different parties. Here is an opportunity to put in a good word for a man who has interested himself in problems of public health and the protection of the people against contagious diseases and the prevention of illness. There is also the opportunity, by the same token, to call attention to the man who has neglected to stand up for these public safety guards. A word from the doctor on

such a subject will have great weight in the average family. Naturally, he should not abuse his privilege and attempt to play cheap party politics; but as long as he sticks to his ideal, he can be a great power for good in the community.

The experience in one of the counties in New York State is worth repeating and we believe it is not generally known. A few years ago the committees of the New York State Medical Society interested in the furthering of public health legislation were confronted in this particular county with a group of politicians who frustrated their efforts. The physicians organized themselves in a body and on their daily rounds discussed the subject with their patients. Naturally a large proportion of the people was reached in this way. At the next election when these same politicians again sought office, every one of them was defeated because of the very effective propaganda instituted by these physicians. What was done in New York State can be done in Rhode Island or in any other community.

Our duty to the public in the matter of public health legislation is self evident and it is our duty as citizens to see that the right men are nominated and elected and that such laws are put upon our statute books. In the same way an organized profession can do much to prevent the inroads of the irregular practitioners who are gaining an important hold upon the public in all parts of this community. The medical profession is passing through a critical stage in its existence, but we cannot correct these evils by ignoring them. We must get together and do co-operative work for the best interests of the public. In this way and in this way only will the medical profession regain the standing which it had two generations ago in the hearts of the public of this nation.

### SOCIETIES

#### PROVIDENCE MEDICAL ASSOCIATION.

Monthly meeting was held Monday, October 2, 1922, at Rhode Island Medical Society Library, Francis Street, at 8:45 p. m.

The following program was offered: "Symposium on Anterior Poliomyelitis." Paper: "Anterior Poliomyelitis as Exemplified in Recent Epidemic," Dr. D. L. Richardson, Providence, R. I.

Other speakers were: Dr. B. U. Richards, Sec-

retary State Board of Health; Dr. Charles V. Chapin, Superintendent of Health; Dr. Charles A. McDonald, Dr. Harvey B. Sanborn, Dr. Carl D. Sawyer, Dr. Murray S. Danforth, Dr. Henry L. Johnson, Westerly R. I.

The Standing Committee approved of the application of William A. Mahoney.

#### WASHINGTON COUNTY MEDICAL SOCIETY.

Quarterly meeting was held at the Elm Tree Inn, Westerly, Thursday, October 12, 1922, at 11 A. M. Paper: "Remarks Upon Recent Studies in Diseases of the Heart," Dr. Frank T. Fulton of Providence.

W. A. HILLARD, M.D., Sec.

### HOSPITAL NOTES

#### RHODE ISLAND HOSPITAL.

Drs. Charles A. Levin and Frank W. Harrah finished two-year internships October 1st.

Drs. John Champlin and Francis Garside started two-year internships October 1st.

The regular annual meeting of the corporation will be held at the Hospital Wednesday, November 8.

The regular Hallowe'en party for the children at the Crawford Allen Memorial Hospital will be held Saturday, October 21.

NORMAN C. BAKER, M.D., Sec.

### MISCELLANEOUS

WE START TO DIE AS SOON AS WE'RE  
BORN! BUT WHY HURRY  
THE PROCESS?

These headlines present a rather startling conception of life. That conception is none the less literally true.

Equally true, is the fact that a careless attitude toward essentials of living—a remarkable failure to put into use established means of conserving health and vigor—provides true grounds for the question above.

We speak with bated breath of thousands killed in battle—and don't even discuss or notice the fact that hundreds of thousands of lives are hurried to an end each year, by absolutely known and preventable causes. We'll thankfully go to a hospital for six, eight or ten weeks, to recover and

convalesce from typhoid or dysentery. But we won't give the few hours of time and the few moments of thought which, given by enough of us, would control these diseases almost to the point of extinction. We'll collectively spend hundreds of thousands of dollars to build tuberculosis sanatoria. And we won't spend a few moments' time, personally, to educate a sufferer of the disease—ourselves or another—in the means of preventing its spread.

Figures available from sources that are beyond question show that more than 250,000 deaths, not to mention 4,500,000 cases of sickness each year, result from neglect of simple and practical means to prevent the spread of typhoid, dysentery, summer complaint, and hook worm. Thus, in our national neglect of sanitation—in which each of us has his individual share of guilt of what amounts to murder—we are allowing ourselves to be killed, each year, in numbers which far exceed the total loss of life in the A. E. F. during the World War.

The research department of the Indiana State Board of Health indicts the outdoor toilet as responsible for 85 per cent of the cases of typhoid. In Johnstown, Pa., as early as 1915, research of the Children's Bureau of Washington, D. C., turned up these facts: In homes where bathtubs were found, the death rate of babies was less than half of that in homes without them. In homes where there was a water closet the death rate was 108.3 as against 169.3 where there were only yard privies. If these facts say anything at all, they shout aloud, "Spread the knowledge and the means of sanitation; insist on safe disposal of sewage and protect water supply from defilement."

Surely it's high time to move along the line of ending this heedless waste of life and health. The National Good Health Week movement is one in which we can all take active part, spreading the idea of better health protection, and extending knowledge of ways and means to that most desirable end. Every time we put into use any of the perfectly available means of modern sanitation—every time we educate and inform our neighbors regarding them—we reduce our own hazard of bad health and help to raise the life expectancy of every member of our families and our communities.

#### ANNOUNCEMENT.

U. S. NAVAL HOSPITAL, NEWPORT, R. I.

Graduates in medicine under 32 years of age actively engaged in practice are urged to consider the Medical Corps of the United States Navy as a field for medical work. Naval medicine is perhaps the most comprehensive of the specialties. A naval medical officer must be a versatile man, well grounded in the fundamentals of his profession.

Besides giving an opportunity to practice medicine upon a high ethical plane and to offer service to one's country, the Navy provides for the development of the man himself professionally and culturally. Naval hospitals in the United States and in our insular possessions offer clinical material of the most varied sorts. Then, too, the travel and the adventure tend to broaden a man's outlook.

The Navy offers assured financial independence from the start. The pay of a lieutenant (junior grade), (rank of medical officer on admission to the service), is \$2,000.00. With dependents, a rental allowance of \$720.00 is added. The subsistence allowance is \$438.00. The pay is increased for each three years of service.

Lieutenants (junior grade) are eligible for promotion to lieutenants after three years. The pay of a lieutenant is \$2,400.00. A rental allowance of \$960.00 is allowed for dependents and the subsistence allowance is \$438.00.

The financial worries and petty annoyances that harass the private practitioner, especially in his early days of practice, are eliminated. Moreover, the Navy not only allows thirty days leave a year, with sick leave as required, but also protects against disability by retirement at three-quarters pay after 30 years' service. Old age is provided for by retirement at the age of 64 years on three-quarters pay.

For further information, address the Chief of the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

#### OBSERVATIONS ON THE HEART IN MOTHERS AND THE NEW-BORN.

Clinical, cardiographic and radiographic examinations made by S. Calvin Smith, Philadelphia (*Journal A. M. A.*, July 1, 1922), indicate that

pregnancy, in itself, does not cause cardiac enlargement. Such evidences of cardiac enlargement as may be present in the expectant mother under certain circumstances of examination are shown to disappear under other circumstances. Cardiac enlargement in the latter half of pregnancy can be simulated by the upward pressure which the gravid uterus exerts on the heart, causing cardiac displacement. There are no heart affections which are characteristic of or incident to pregnancy. While pregnancy, in all likelihood, throws a load of some degree on the heart, the heart is as fully capable of adapting itself to this as to other physiologic demands. A definite history of previous infections requires that the expectant mother be closely observed, as pregnancy advances, for symptoms of masked heart disease, which may not become apparent until brought to light by the heart load of pregnancy. Focal infections may cause symptoms of heart embarrassment in pregnant patients, which might erroneously be attributed to pregnancy. Definite cardiac indications for the interruption of pregnancy are rare. Even frankly diseased hearts will exhibit a surprising adaptability to the physiologic demands of pregnancy. The right side of the heart is enlarged in the new-born. Evidence of cardiac enlargement persists for five weeks, or longer, before the baby's record begins to assume adult characteristics. The heart, following birth, is frequently irregular at intervals during the first week. Such irregularities may be expected to disappear at a later date and are not indicative of cardiac pathology. Graphic records suggest that it may be possible for maternal irregularities to be transmitted to the child. In a stillborn baby, evidences of heart activity were observed for three hours and twenty-four minutes following stillbirth. Massage of the heart through the chest wall may prove to be a useful adjunct to other methods of resuscitation in the stillborn.

#### PROVISIONAL BIRTH FIGURES, 1922.

Washington, D. C., August 31, 1922.—The Department of Commerce announces that provisional birth figures compiled by the Bureau of the Census for the first quarter of 1922 indicate lower birth rates than for the corresponding quarter of 1921. For the States compared, the total birth rate for the first quarter was 23.3 in 1922 against

25.3 in 1921. The highest birth rate for the quarter (29.2) is shown for North Carolina and the lowest (16.5) for the State of Washington. Higher rates will be necessary for the remaining months of the year if the 1922 rate is to equal the 1921 rate for the birth registration area—24.3.

#### LEGAL STATUS OF PHYSICIANS AND SECTARIANS.

Summarizing the discussion of this subject, Frederick R. Green, Chicago (*Journal A. M. A.*, Sept. 23, 1922), says that the regulation of those desiring to treat the sick should be based on educational rather than sectarian standards. Such regulation should be administered by the State educational authorities. For economical and efficient administration, the regulation of all professions, occupations and trades supervised by the State government should be placed in the hands of a single State department, which should have as its head an educator of recognized standing and demonstrated executive ability. Whatever machinery for regulation is adopted, it should be recognized that the object for such regulation is the protection of the public, and that the people should pay for this protection as they pay for protection from any other danger. Such laws are emphatically not intended for the restriction of competition among practitioners. A third principle on which the medical profession should insist is that all persons desiring the same privileges should be required to comply with the same educational standards, without regard to the school from which they graduated or the sect to which they belong.